Overview & Scrutiny Committee

Tuesday, 23rd November, 2021
6.00 - 7.40 pm

Attendees	
Councillors:	Chris Mason (Chair), Dilys Barrell, Nigel Britter, Alisha Lewis, Emma Nelson, John Payne, Julie Sankey, Jo Stafford, Paul McCloskey (Reserve) and Simon Wheeler (Reserve)
Also in attendance:	Councillor Steve Harvey, Bev Thomas, Harry Mayo, Councillor Flo Clucas, Councillor Rowena Hay, Darren Knight, Councillor Mike Collins and Councillor Matt Babbage

Minutes

1. **APOLOGIES**
   Apologies were received from Cllrs. Flynn and Hegenbarth. Cllrs. McCloskey and Wheeler substituted for them.

2. **DECLARATIONS OF INTEREST**
   Cllr. Nelson declared an interest as the spouse of the Police and Crime Commissioner.

3. **MINUTES OF THE LAST MEETING**
   The public minutes of the meeting held on 4th October were approved and signed as a correct record.

4. **PUBLIC AND MEMBER QUESTIONS, CALLS FOR ACTIONS AND PETITIONS**
   There were none.

5. **MATTERS REFERRED TO COMMITTEE**

6. **COUNCIL MOTION - 18TH OCTOBER 2021**

   Mark Walkingshaw (Deputy Accountable Officer, NHS Gloucestershire Clinical Commissioning Group) (MW) gave a presentation on the pressures facing the NHS Trust and its partners and how these were being addressed, and informed Members of the winter plan and how they could support the Trust going forward.

   He acknowledged that the NHS and social care system were undergoing significant pressure, and they the need to be open and honest about the challenges faced and the responses needed. The winter plan had been pulled together with all partners, as it was on an annual basis, but was different this year due to the ongoing impact of Covid-19 on a wide range of actions. This

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was set alongside the normal winter challenges, such as seasonal flu and respiratory diseases like respiratory syncytial virus (RSV).

They also needed to plan for significant workforce challenges across the health and social care system, which were even more pronounced as a result of the pandemic as the economy recovered and different sectors competed for staff. There had been particular pressures this year on recruiting and maintaining nursery, domiciliary and care home staff – part of a wider national issue which had received significant media coverage.

The focus was increasingly on joint work with adult social care services, which had significantly changed in terms of the scale of pressures. There was a build-up of patients who could be discharged but lacked proper pathways like returning home or moving into a care home. They needed to work closely with the adult social care system to solve this.

He reflected on what they had learned from the first phases of the pandemic, and emphasised that the system would succeed if it worked together and escalated together. A series of metrics was reviewed hourly to inform actions that they needed to take as system partners, across general practice, the ambulance service and more. He highlighted the increased importance of digital technology and the ways in which staff deployment and flexible working had been affected by the pandemic.

He acknowledged that there were risks within the winter plan, including demand possibly exceeding capacity, workforce pressures, risks related to increased Covid cases, difficulty in maintaining operational performance standards, increased activity in NHS 111 and out-of-hours, and patients deconditioning. Despite this, the vaccination program continued to be key, with Gloucestershire and its primary care networks performing excellently.

The winter plan would be supported by system-wide capacity and demand modelling, with detailed work having taken place with business intelligence teams to model this and set up the Single Health Resilience Early Warning Dashboard (SHREWD) system.

Key actions taken to reduce ambulance handover delays included identifying new cohorting areas, referring sub-acute cases to Community Hospitals, incorporating senior clinical advice and enabling additional back door capacity. Meanwhile, the expansion of the Cinapsis service supported patients diverted away from the emergency department and delivered care in alternative settings. A system-wide information sharing service had been developed.

He concluded by outlining the next steps. Additional recruitment for key schemes needed to be progressed, while system pressures and responses were continually reviewed. They would also continually evaluate the impact of all initiatives, influence and build on changes in patient behaviour, and repurpose or redirect resources where needed.

Member Questions

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1.	Question from Councillor John Payne
	I hope you will agree that your staff are your most valuable resource. I would appreciate it if you could convey to the Committee your views on the current position, in particular where are staff shortages impacting on the current provision of services and what action is the Trust taking to address this issue.
	Response from the ICS
	Yes, staff are definitely our most valuable resource and we are doing everything possible to continue to support all health and social care staff across the county. In particular recognising the many challenges the pandemic has created during the last 18 months. This includes a range of staff health and well-being measures, practical measures taken to date include ensuring all staff continue to take breaks and annual leave, ensuring good access to mental health support, subsidising meals, contributing to car parking costs etc. In terms of workforce pressures, in common with other parts of the country, these are being experienced across the health and social care system with particular challenges experienced in relation to the recruitment and retention of nursing staff within the NHS and domiciliary and care home staff within the adult social care sector. *Please also see answer to question 5 for more detail on the specific initiatives in place to support staff at both Gloucestershire Hospitals NHS Foundation Trust (GHFT) and South Western Ambulance NHS Foundation Trust (SWAST).* As a system we have worked together to take a number of further targeted actions. There is a system wide 'People Framework' that allows organisations to share staff when required. This was used during the first phases of the pandemic and, more recently, to enable staff to be shared across the system to deliver the vaccination programme. Specific actions taken to address workforce shortfalls include use of bank and agency staff, international recruitment, partnerships with the third sector, staff passports (to allow staff to work more easily across different parts of the system) and system wide recruitment and retention programmes.
	Supplementary question from Cllr. Payne
	I would like a wider understanding of what these backlogs are and what the ICS is doing to address them. Subsidised meals/car parking are not enough, and many Trusts do that already. Where are the most significant staff shortages?
	Response from the ICS
	The key sign of an effective service is not constantly hiring new staff, but maintaining who we have already got. We are working hard to do this despite the loss of national funding, which was reinstated this week. It is more about a lack of capacity overall rather than specific areas for shortages – the challenge is in supporting people to leave hospital when they are ready to do so. Turnover and vacancy rates are key in reducing waiting times and maintaining bed capacity. Staff levels differ in every department – for example, the recruitment of overseas radiographers has been a huge success. The biggest area of concern is social care, since it

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	is difficult to deliver good healthcare without a robust social care system.
2.	**Question from Councillor John Payne**
	Your "Live A&E waiting times" you publish on the internet does not provide information on waiting times, just that you will be triaged within 15 minutes. Triage is not treatment. The NHS statistic for September shows that only 60% of patients were seen within the 4 hour target, making GNHS Trust one of the worst performing trusts in the country. Could you please provide a breakdown of wait times at GRH and CGH, and do you count the time of triage as "receiving treatment"?
	Response from the ICS
	The 4 hour waiting time standard is a measure of the time period from a patient being booked into A&E and being discharged home or admitted to hospital. Triage is the process by which patients are assessed by a clinician and given a clinical priority using a recognised national triage score.

Performance against the Emergency Department four hour standard is under daily pressure across the country. GHFT and system performance is currently in the 'middle of the pack' in terms of our relative position compared to other parts of England. *However all parts of the system continue to be committed to further improve this performance and further reduce waiting times.*

Performance for the most recent week shows performance above 70% against the 4 hours *maximum* wait standard.

In terms of the last full month, in October Gloucestershire Hospitals NHS Foundation Trust saw 62.2% of patients within a maximum of 4 hours or less. Taking all settings the Gloucestershire system saw 73.3% of patients in all settings within the maximum of 4 hours. Both GHFT and Gloucestershire's performance has improved compared to the previous month.

In October, of the one hundred and eleven providers in England with a Type 1 A&E service, GHFT ranked 55th and Gloucestershire ranked 21st out of 42 systems (in terms of the overall percentage of attendances within 4 hours) and 17th in terms of type 1 activity. |
	Supplementary question from Cllr. Payne
	Could you clarify the meaning of 'clinician' in reference to triage?
	Response from the ICS
	'Clinician' refers to anyone with a clinical qualification. Triage is usually carried out by a clinician or senior nurse, but they are constantly looking at how triage protocols can be improved in order to reduce waiting times. A new 'pit stop' system has been trialled recently, where the consultant or registrar assesses the sickest patients on arrival to ensure they can be dealt with as soon as possible. There is always a balance to be found.
3.	**Question from Councillor John Payne**

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	As an outsider it is difficult to define the causes of the failure of GNHS Trust to provide and acceptable level of service, particularly A&E services. Could you please highlight what you see as the main areas of concern and how are these to be addressed.
	Response from the ICS
	GHFT aims to provide high quality, safe and effective urgent and emergency care services as part of the wider urgent and emergency care system in Gloucestershire.
	There are a number of factors impacting upon A&E performance at present, these include in particular:
	• The ongoing impact of the Covid-19 pandemic (in terms of additional infection prevention and control measures, the admission of Covid patients, Covid related staff absence etc.).
	• Pressure caused by discharge delays from hospital. This sometimes leads to delays in being able to admit patients from the Emergency Departments and can sometimes lead to Ambulances queuing as pressure builds during the day/into the evening. These high numbers of discharge delays are due in particular to the pressure upon out of hospital and home based onward pathways for patients and reflects the wider pressure upon community and adult social care services. *This continues to require a whole health and social care system response (see list of system actions below).*
	• Workforce pressures across all parts of the health and social care system (contributing to the above capacity issues).
	All system partners continue to work closely together to respond to these pressures and additional actions taken to date have included:
	• Putting in place additional doctors and nurses within the services provided by NHS 111, Out of Hours GPs and SWAST (i.e. increase in the trained doctors and nurses able to take call from patients).
	• Increased use of community and rapid response teams to support A&E, reduce unnecessary admissions to hospital and facilitate discharge.
	• Commissioning additional 'Discharge to Assess' care home capacity supporting more people to have their Adult Social Care or Continuing Health Care assessment in another setting to avoid a delay to hospital discharge (e.g. in a specially commissioned care home bed).
	• Commissioning additional home based care alongside additional respite care capacity.
	• The introduction of an Enhanced Independence Offer/Increase in 'Home First' capacity. This is a discharge pathway for individuals who are not safe to be discharged home without some level of support. The service is "therapy led" for a maximum of 10 days and works closely with the person to promote their independence.
	• All community hospital beds have been prioritised for acute hospital transfers including 'flexing' admission criteria to support

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	those patients waiting assessment/home based pathways. • The use of patient cohorting areas within A&E during times of particular pressure. • Opening of additional inpatient escalation areas within the hospital during times of pressure. • The cancelling and rescheduling of some non-urgent planned surgery during periods of escalation. • The recruitment of a senior system lead for discharge and flow to co-ordinate the key programmes of work across the system and to manage daily escalation processes pertaining to flow. A wider set of actions is being taken by GCC, GCCG and system partners to help stabilise the domiciliary and care home markets (some of which are referenced above). These include: • Provider relief funding: providing additional funding to providers from the Covid Emergency Fund including helping to meet additional infection control, testing and workforce costs. • Actions to support retention and recruitment: Most of these are extensions of work already in development by our 'Proud to Care' team. They include activities to promote jobs, select and recruit staff, increase training opportunities for staff and the promotion of care as a career as well as recognition of the value of our care workforce.
	Supplementary question from Cllr. Payne
	Many staff are likely unaware of all these initiatives, such as the 'Proud to Care' development. What is this, and when will its results be seen?
	Response from the ICS
	The 'Proud to Care' project is an initiative which relates to social care alongside the county council and across many systems in the South West, and seeks to support staff and help them grow to work across the whole system.
4.	**Question from Councillor Dilys Barrell and Councillor Flo Clucas**
	Please could you tell us about the various types of Alert levels used in health care, in particular the Black Alert /Opel 4 / internal incident: • What are the criteria which trigger each of these levels of escalation? • Who do the Trust have to inform when they declare each level? • Which services are involved? • What actions are staff and partners expected to take in response to each level of escalation? • Is there any way CBC could help on these occasions?
	Response from the ICS
	There are two main reported escalation levels, a system escalation level and an individual provider escalation level. They both use the national Operational Pressure Escalation Levels (OPEL) definitions and these align with the National Resource Escalation Action Plan (REAP) comprising of 4 distinct levels:

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		• OPEL 1 (Green) The local health and social care system capacity is such that organisation are able to maintain patient flow and are able to meet anticipated demand within available resources. • OPEL 2 (Amber) The local health and social care system is starting to show signs of pressure, focussed actions are required in organisations. • OPEL 3 (Red) The health and social care system is experiencing major pressures which are compromising patient flow and these continue to increase. Further urgent action required across the system. • OPEL 4 (Black) Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised. All available local escalation actions taken, external extensive support and intervention required. The status of the system is assessed each day by the submission of a set of data from each organisation which is put together through our daily reporting system in order to assess the overall positon. As a system we are currently at OPEL 3 (Red). All parts of the system are required to submit this data every day of the week. All parts of the health and social care system are covered by this process including NHS 111, SWAST, acute and community providers, social care etc. SWAST uses REAP levels Green through to Black to determine and communicate the escalation level. There is a system wide and individual NHS provider escalation plan which details each action which will be taken at each level of escalation to relieve the pressure upon the system. This is support by a series of escalation calls which take place each day and Gold (CEO level calls) which take place across the week. In terms of support during these periods of pressure CBC could continue to support our 'Click or Call First' campaign messaging to the public, regarding the use of Urgent and Emergency Care Services. The great majority of people with minor illness or injury are continuing to access services appropriately.
		Supplementary question from Cllr. Barrell
		What is the 'Click or Call First' campaign, and how can the council help support it?
		Response from the ICS
		This project is yet to be launched but has already received strong support from CBC. It is effectively a campaign to reinforce the ways the public can access urgent care services, particularly NHS 111, local GP services and pharmacies. They need to put out clear messaging around it, and the council and the public can help by spreading and reinforcing the message that the public should continue to access healthcare at an appropriate point. Every part of the system is working as hard as possible to deliver

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	fantastic primary care in Gloucestershire, demonstrated by how 10% more appointments have been provided than in a comparative pre-Covid year.
	Supplementary question from Cllr. Clucas
	The system is currently at OPEL 3. How long has that been the case, and has it ever been at OPEL 4?
	Response from the ICS
	The system has been at OPEL 3 consistently for the last 3 months. It has never tipped over into OPEL 4, although many neighbouring systems have. Level 4 means that services are compromised and you would need mutual support, so we do all we can to avoid that. We are not aware of any Trust operating at level 2 recently, so 3 is very much the norm. A move to level 4 would have to be approved by NHS England. It was important to be clear about the difference between business continuity plans and managing escalation and the OPEL levels. The Trust may send out communications to staff regarding de-escalation, but this doesn't necessarily mean OPEL 4 has been reached.
5.	**Question from Councillor Dilys Barrell**
	Staff must be working under enormous pressure at the moment. What measures are there in place to support their mental health? Are there any problems with staff shortages? Can you tell us about the measures you have in place to help retain staff and recruit new ones? Is this an area where CBC could help?
	Response from the ICS
	There are a number of initiative in place to support the mental health and well-being of all NHS staff. These include access to a range of mental health support as well as wider health and well-being programme. The following summarises just some of the key initiatives in place within GHFT and SWAST. Examples of GHFT wellbeing initiatives include: ▪ a Staff Support and Advice Hub which staff can contact for support in relation to their psychological wellbeing, this is able to facilitate access to telephone counselling services and occupational health advice; ▪ the Trust has a large number of Trauma Risk Management (TRiM) Practitioners who are front line staff who have been additionally trained to identify and support those at risk of mental health problems in their teams; ▪ the Trust introduced Psychology Link Workers during the pandemic and these remain in place and are clinical psychologists who work with teams and individuals to support their mental health and psychological wellbeing. Examples of SWAST wellbeing initiatives include: ▪ wellbeing support provided by an in house Staying Well Service; ▪ access to formal based counselling, physiotherapy, coaching and alternative therapies to provide specialist support to retain and

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help with returning to work, like GHFT a Trauma Risk Management (TRiM) is available for when employees have attended a traumatic event;
- welfare cars have been made available;
- Employee Assistance Programme service app, providing access to 24/7 counselling support;
- long Covid support through Outreach Support Workers;
- psychological wellbeing packs shared with all employees.

In terms of the establishment position SWAST are projected to have an over established position of 125 whole time equivalents (WTE) by the end of this financial year. In order to achieve this, they have recently recruited an additional 50 WTE paramedics in order to reduce the requirement for incentive and overtime shifts because it is recognised this will be contributing towards employees' fatigue. In terms of Gloucestershire SWAST are projecting a year end paramedic over establishment of 22.

The issues in relation to system workforce challenges are covered in the earlier answer but in terms of areas where CBC could offer support, there is a particular need to ensure all NHS and social care staff continue to feel supported and valued during what we know will continue to be a challenging period. If there is any way the council could help to continue to communicate this through their public messaging would be very much appreciated.

	Supplementary question from Cllr. Barrell
	Have the Trust carried out surveys (ideally anonymously) to find out whether staff feel properly supported?
	Response from the ICS
	There are many different ways that we try to understand how frontline staff are coping, including constant dialogue in A&E departments and the 'barometer' system, which allows staff to anonymously report how they are doing and about any difficulties in their role.

A national survey of staff welfare is currently taking place, and will close on 26th November. It will run for 6 weeks in total and is overseen by an independent, external body. The results will be published in January 2022 and it will be good to be able to compare Gloucestershire to other Trusts around the country.

Additional support is also in place for BAME, LGBT and disabled staff. |
| 6. | **Question from Councillor Dilys Barrell** |
| | Do you have the resources you need to cope with the increased pressure services are under? Can CBC work with you and help in any way?

(I am wondering about such things as giving residents information about appropriate use of services, e.g. when to use 111 or the use of "what 3 words" to pinpoint a location for ambulance staff) |
| | **Response from the ICS** |

	Additional national funding has been received by both the NHS and GCC to help ensure we are able to respond to the current pressures (with the GCC funding focussed upon further support to the ASC workforce). In particular this is being used to recruit additional staff and to purchase additional equipment in order to put us in the best possible position in order to be able to respond to the challenges the system faces this winter.
	It should be noted that as well responding to the urgent and emergency care pressures facing the system, this is also being targeted at furthering the progress already made in reducing the number of patients and the time patients currently wait for planned treatments (including diagnostics, cancer care and planned procedures/treatment).
	Please see answer at 4. above regarding 'Click or Call First' campaign.
	Supplementary question from Cllr. Barrell
	What is the ASC workforce?
	Response from the ICS
	This refers to adult social care.
7.	**Question from Councillor Flo Clucas**
	On 8th November at 11.50am, waiting time to be seen by a doctor in A&E at the RGH was 394 minutes (6hrs 56 minutes) with 94 people in the queue. At CGH, the waiting time was 84 minutes, with 30 people in the queue. At 12.32, there were already 15 ambulances queueing outside the A&E department.
	Emergency ambulances were not able to respond to many emergency (999) calls because so many are waiting outside A&E departments.
	It would help the Committee's understanding of the process if the Hospital Trust could please explain the escalation framework it uses:
	• How it judges when to declare a 'Critical Incident', a 'Reset Day' or any other kind of 'Incident'. Particularly as one was declared this week, prior to the Opel 4 declaration.
	• How it grades such incidents: for example by Number 1,2,3,4, or colour- Green, Amber, Red, Black - as in the national NHS Framework. Operational Pressures Escalation Levels (OPEL); or as Resource Escalation Action Plan (REAP), or by some other method? If so, can the Trust please define what it means by 'Alert', 'Internal Incident', 'Internal Critical Incident' and Reset Days and how these relate to the above?
	Response from the ICS
	The Trust has in place a detailed internal escalation policy which contains a series of triggers which prompt specific escalation actions. *The Operational Pressure Escalation Levels are as set out in the answer to question 4. above.*

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	The Trust moves into 'Internal Incident' when a different level of response is required, this can for example mean that some routine activities (which do not contribute to responding to the immediate pressures) are stood down, that staff are redeployed or additional staff are called in to the hospital to help with the response. It also means that non-urgent meetings or training may be cancelled to release staff.
	Supplementary question from Cllr. Clucas
	What are the triggers which prompt specific escalation points? For example, is there a particular length of ambulance turnaround or a percentage threshold of cases reaching the 4 hour limit?

Is it correct, as the Nuffield Trust has stated, that Opel Red and Black correspond to the old term 'black alert' or 'major incident'? |
	Response from the ICS
	We have a comprehensive document outlining the criteria for OPEL levels, which we will share with Cllr. Clucas after the meeting. To respond to specific examples, ambulances and bed capacity would generally be level 3 while waiting times would be level 2. OPEL 4 would relate to system-wide pressure, which is why the Trust could not declare it itself. Some indicators can vary, for example having capacity but not Covid capacity, or a surge in paediatrics. It all depends on demand, staff, patients and what we can discharge. We are not familiar with this statement from the Nuffield Trust but will look into it.
8.	**Question from Councillor Flo Clucas**
	The Hospital Trust is fined if it is unable to unload emergency ambulance patients within 30 minutes and fined even more when it is unable to unload them within one hour. Did the Hospital Trust inform the Ambulance Service, it's Commissioners, or any of its other partners, when it started to be unable to unload patients from emergency ambulances within the target times? Did this count as a formal alert within the above framework? If not, why not?
	Response from the ICS
	There are no financial penalties imposed for Ambulance Handover delays and SWAST receives no funding linked to this. This is not just a GHFT issue but rather a system issue as reflected in the system wide action plan and escalation processes. It is also important to emphasise that ambulance handover delays can also be seen as a symptom of the wider demand and capacity pressures being experienced across the health and social care system.

Ambulance handover delays form a key part of the daily assessment of the pressures facing the system and inform the escalation level and actions. |
| | **Supplementary question from Cllr. Clucas** |
| | Does this mean that the financial penalties formerly applied by the PCT and CCG in relation to turnarounds of more than 30 minutes have been |

	waived?
	Response from the ICS
	These financial penalties were suspended nationally some time ago and later removed, reflecting the fact that ambulance delays were a reflection of wider system issues. It was deemed inappropriate to levy a financial penalty on one part of the system when all parts of the system were responsible.
9.	**Question from Councillor Flo Clucas**
	What communications took place between the Hospital Trust and SWAST management over the Hospital Trust's inability to unload patients within the target times and the impact this was having on the efficiency of the ambulance service? It was frequently taking between three and five hours to unload patients and peaking at between ten and fifteen hours. At times there were between 12 and 27 ambulances queuing outside GRH ED. On at least one occasion there were over 30 Class 1 Ambulance calls outstanding because there were no emergency ambulances available because they were all waiting to unload patients outside GRH ED.
	Response from the ICS
	Operational teams in both GHFT and SWAST are in regular contact with each other every day and the Trust has members of the SWAST team on site with them and has access to the SWAST system which gives details of the numbers of ambulance calls, ambulances on route to ED etc. The focus of the Trust and the wider system continues to be upon releasing ambulance crews as quickly as possible (see list of actions above). All patients are assessed upon arrival and monitored whilst they are awaiting treatment.
	Supplementary question from Cllr. Clucas
	When was the Hospital Ambulance Liaison Officer (HALO) position created? And if the focus of the Trust and the system continues to be on releasing ambulances as soon as possible, why has it not been able to achieve this?
	Response from the ICS
	It is not a new role, and has been in place for some time. The role has been generally successful although one person cannot achieve zero ambulance delays. It is affected by a complex range of factors.
10.	**Question from Councillor Flo Clucas**
	What was the nature of the notice circulated to Hospital staff on 19th September? That situation was referred to again in internal notices on 23/24 September and again on 05 October. Was that some kind of internal escalation? If so, where in the escalation framework did it rank? 2, 3, or 4, or 'Amber', 'Red', or 'Black'?
	Response from the ICS

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	This related to the Trust's internal escalation status, please see earlier response regarding the various levels of escalation.
Supplementary question from Cllr. Clucas	
	Was the specific notice circulated to hospital staff on 19th September an internal critical incident, and if so at what OPEL level?
	What is the difference between an internal critical incident and a critical incident?
	What is a reset day?
	How many beds are there in each of our hospitals, and has this decreased? What has the impact of this been on patients and care?
Response from the ICS	
	The dates referred to are internal incidents which do not necessarily operate under the OPEL framework. Internal communications don't declare an OPEL level. This particular incident referred to capacity challenges and galvanising the response to this at both front door and back door levels. Declaring an internal critical incident allows us to park some of the routine work that we do and focus attention on a particular area in order to de-escalate, either at the front door or back door.

The reset day was something that ambulance colleagues operated last Monday, where they resourced the day differently to reduce the 'stack' of people waiting to be seen across the country. This saw varying degrees of success across the regions.

There are approximately 895 fewer beds, which is fewer than in the past by default. We used to have about 125 medically optimised for discharge patients, and there are now 225. This means they are technically 100 beds short from pre-pandemic levels, but in reality there are 100 more patients who would not have been in beds pre-pandemic. Additionally, the bed base was reduced on occasion to maintain social distancing, leading to a loss of around 160 beds at its peak when 2 metre distancing was required. Some of these have returned, and the situation fluctuates based on circumstances by as many as 100 in a single day. Difficulties with pathways to care facilities and access to care mean that up to 200 beds may be taken up by patients who could be discharged but do not have anywhere to go.

The vaccination and Covid status of patients are continually monitored to avoid infection, and we must continually balance risk and make judgements on where is best to treat patients, while assessing where the greatest risks are in the system. |

Member debate

Cllr. Stafford (JS) agreed that the flow of patients was critical, and that it was good to see constant monitoring. Did NHS 111 feed into that? MW responded

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that it was a useful indicator of demand, but the focus was on what happened to patients next. The evidence suggested that when patients had access to clinical advice through 111, they were more likely to go to the appropriate service.

Qadar Zada (Chief Operating Officer, Gloucestershire Hospitals NHS Foundation Trust) (QZ) added that they did not wait for OPEL level escalation, and it was a rigorous process that was monitored throughout the day. There was constant contact with the wider system, including twice-weekly calls with Chief Executives across the whole system. They would never get to a situation where the escalation level was a surprise.

Cllr. McCloskey (PMC) recounted a recent experience in hospital where he had been impressed by the resilience and humour of staff, and suggested that managing resources was key. How much work was going on to prevent inefficiencies within the system, such as misdirected patients?

Professor Mark Pietroni (Director of Safety and Medical Director, Gloucestershire Hospitals NHS Foundation Trust) (MP) responded that anybody who came to A&E had their fully digital medical record automatically sent to general practice, enabling immediate feedback on patients. They had compared individual practices to see what could be improved. Indices of deprivation were relevant, as they had found that those from deprived backgrounds were more likely to come to A&E.

MW added that national research on this had found that small parts of the population had particular needs, both physically and mentally. They were constantly analysing most frequent patients, such as those who used A&E more than 5 times a year, to see whether services could be 'wrapped around' them.

Cllr. Lewis (AL) noted that the NHS was a regular topic of discussion with constituents, with ambulanced and A&E queues being particular areas of concern. She was worried that individuals might decide not to go to hospital if they were worried about the queues, and asked how these changes in behaviour were being modelled and addressed. MP agreed that it was imperative to avoid discouraging people from accessing care. Their public messaging was around accessing care in the most appropriate place, to avoid overwhelming A&E. It was a problem in the early pandemic that many people did not access care, as they were presumably concerned about contracting Covid in hospitals or surgeries, and it was important to discourage this.

Deborah Lee (Chief Executive, Gloucestershire Hospitals NHS Foundation Trust) (DL) noted that a key factor in effective care was communication. The BBC had reported last month that 18 ambulances were backed up outside Gloucestershire Royal, when the reality was 7. It was important to tackle misinformation and avoid discouraging people from accessing care.

MP added that while there were concerns about cancer diagnoses being reduced, for example, Gloucestershire's rates were down by less than the national average. Front door services were struggling but cancer pathways were doing as well as before. Routine surgeries were unsurprisingly way below pre-pandemic levels, but were performing well in Gloucestershire compared to the rest of the country.

AL queried the efficiency of the NHS 111 service, noting that one of her constituents had called it at 11pm and received a call back at 4am. MW was concerned by this, and acknowledged that the service had been relatively volatile during the pandemic, especially during the vaccine rollout. In response to that, they had invested an extra £250k before the end of the year on top of national funding to address this increased demand and need for more call handlers. AL clarified that the constituent's issue had been within the last month. DL acknowledged that the 111 service was sub-optimal at the moment, but reassured her that the issue was recognised and understood at the highest level.

Mary Hutton (Accountable Officer, NHS Gloucestershire Clinical Commissioning Group) (MH) added that they were encouraging people to contact their GP first during their hours as well as other services like pharmacies to spread the load.

Cllr. Sankey (JS) asked whether patients in adult social care were being supported outside of hospital, and whether there was a shared database. MW clarified that there was close involvement between services and a heavy push by the NHS for new services. For example, more assessments were being done outside of hospitals and in homes instead, which was the ideal environment for them.

JS noted that the presentation had looked at frail and elderly people and asked how resources would be allocated to prevent inefficiency – for example, sending ambulances to help people who have fallen down. MH responded that a new service was being developed for the winter which was a rapid response service for people who had fallen.

Cllr. Barrell (DB) noted that she had been impressed by the quality of care during a recent hospital visit. The loss of beds was a key issue, with the Guardian reporting last week that the number of beds in the UK had fallen from 169,000 hospital beds in 2010 to 132,000 in 2021. DL noted that this was partly due to advances in technology – for example, the new robotic technology used to reduce the length of bladder surgery from 10 days to 5 reduced the need for beds. This was offset by increased demand for urgent and emergency care as the average population continued to get older.

PMC asked how increased mental health need was being dealt with. MP noted that one of the key effects of Covid had been on mental health, with a significant rise in eating disorders for example. School closures and lockdowns had also increased anxiety in children and vulnerable adults. The effect on mental health services was clear and sometimes this split over into emergency departments. Hospital was rarely the best place to deal with mental health disorders, and he added that they continued to invest in preventative mental health services such as talking therapies, community support and low-level mental health services for both younger and older people.

Cllr. Nelson (EN) noted that Gloucestershire had the lowest response rate to eating disorders in the country. What was being done to address this? DL agreed that Gloucestershire lacked service provision on this topic, and although they were doing myriad things in order to address it, the pandemic had been a perfect storm with demand soaring. Eating disorders were harder to identify

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when people were staying at home and not venturing out like normal. She agreed that hospital was rarely the right place for someone with an eating disorder, other than in immediate severe situations like refeeding. In-patient care could be beneficial, and community-based services were key but they were currently struggling with demand.

Cllr. Britter (NB) asked how they could combat misinformation. MW suggested that clarity and simplicity were key. There was a dedicated communications team within the clinical commissioning group which was working hard to simplify messages and ensure they landed with the public. He emphasised importance of the message coming directly from clinical leads, who were particularly authoritative with the public.

Cllr. Mason (CM) suggested bringing health and social care under one body, lest the bodies end up competing with each other. MH responded that they were moving towards a statutory Integrated Care System next year. There was regular contact between health and social care, and they worked closely together and sharing resources. Recruitment issues affected the whole system and would not be solved by a restructure. MP emphasised that the public did not care precisely which organisation did what, but rather what was actually done. Organisational structure was always secondary to outcomes, and he was concerned that a restructure would make things worse before they got better. QZ reassured members that the problems faced were not organisational, but were rather about challenges to the workforce.

CM summed up the key message as being that members needed to help with messaging to residents about accessing care at the appropriate point. On behalf of the council, he thanked the representatives for their contributions to the meeting and the wider NHS staff for their efforts.

7. **FEEDBACK FROM OTHER SCRUTINY MEETINGS ATTENDED**
Cllr. Barrell's update from the Gloucestershire Health O&S Committee on 12th October 2021 was taken as read.

Cllr. McCloskey's update from the Gloucestershire Economic Growth O&S Committee on 20th October 2021 was taken as read.

Cllr. Brownsteen's update from the Gloucestershire Police and Crime Panel on 3rd November 2021 was taken as read.

8. **CABINET BRIEFING**
The Leader did not have anything to report.

9. **REVIEW OF SCRUTINY WORKPLAN**
There were no comments from members on the scrutiny workplan.

10. **DATE OF NEXT MEETING**
17th January 2022.

11. **LOCAL GOVERNMENT ACT 1972 - EXEMPT INFORMATION**

Draft minutes to be approved at the next meeting on Monday, 17 January 2022.

12.   EXEMPT MINUTES

Members resolved to move into exempt session.

The exempt minutes of the 4th October meeting were approved and signed as a correct record.

Chris Mason
Chairman

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